

The Stellenbosch Consensus on the International Legal Obligation to Collaborate and Assist in Addressing Pandemics

Clarifying Article 44 of the International Health Regulations

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Abstract

The *International Health Regulations* (IHR), of which the World Health Organization is custodian, govern how countries collectively promote global health security, including prevention, detection, and response to potential global health emergencies such as the ongoing COVID-19 pandemic. While Article 44 of this binding legal instrument requires countries to collaborate and assist each other in meeting their respective obligations, recent events demonstrate that the precise nature and scope of these legal obligations are ill-understood. A shared understanding of the level and type of collaboration legally required by the IHR is a necessary step in ensuring these obligations can be acted upon and fully realized, and in fostering global solidarity and resilience in the face of future pandemics. In this consensus statement, public international law scholars specializing in global health consider the legal meaning of Article 44 using the interpretive framework of the *Vienna Convention on the Law of Treaties*.

Keywords

Vienna Convention on the Law of Treaties – treaty interpretation – international health regulations – international organizations – World Health Organization – international duty to assist – global health governance – international human rights law

1 Introduction

The *International Health Regulations* (IHR) is a legally binding international instrument that governs how 196 states parties collectively promote global health security, including preventing, detecting, reporting, and responding to infectious disease outbreaks that pose major global threats. Its most recent version was adopted unanimously in 2005 by the World Health Assembly under Articles 21(a) and 22 of the Constitution of the World Health Organization (WHO). This revision to the IHR followed the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003 that exposed weaknesses in the IHR's previous version and garnered worldwide support for fundamental changes. The revised IHR aims to "prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade".¹

When renegotiating the IHR, countries discussed at great lengths how this important legal instrument must require countries to support each other in curtailing the international spread of diseases for everyone's benefit.² Article 44 of the IHR is the outcome and legal embodiment of this identified need: it legally requires collaboration between states parties and from WHO for the fulfillment of the IHR's other obligations. This need continued to be discussed after the IHR's entry into force in 2007. Most prominently, that year WHO focused its marquee *World Health Report 2007* on how the IHR facilitates collective responses to global health security threats through global partnerships and international collaboration, with the WHO Director-General emphasizing that "[i]nternational public health security is both a collective aspiration and a mutual responsibility".³ Yet, despite the importance of this need and its encapsulation in Article 44 of the IHR, there is little legal guidance available to countries to better understand the precise nature and nuances of their collaboration obligations. As described in the introduction to this special issue of *International Organizations Law Review*, this article contains the second of two consensus statements that apply generally accepted principles and doctrine of public international law to interpret countries' legal obligations under the IHR. This second statement clarifies the duties countries have under

1 *International Health Regulations* (2005) entered into force June 15, 2007, art. 2 [hereinafter *IHR* (2005)].

2 Who, "The World Health Report 2007 A Safer Future: Global Public Health Security in the 21st Century" <https://www.who.int/whr/2007/whr07_en.pdf?ua=1> [hereinafter *World Health Report 2007*].

3 *Ibid.*, vii.

Article 44 of the IHR to collaborate and assist each other in preparing for and responding to public health events.

For historical context, the IHR can be traced back to the earlier International Sanitary Conventions adopted between 1892 and 1944, that were brought together by the World Health Assembly in 1951 as the *International Sanitary Regulations*, and then revised and renamed in 1969 as the *International Health Regulations*. The IHR (1969) applied only to four diseases: plague, cholera, yellow fever and smallpox.⁴ Additional quarantinable diseases were added in 1973 and in 1981.⁵ The Regulations as revised in 2005 (IHR (2005)) represented a more “substantial revision”,⁶ including significant changes to how countries were expected to prepare for and respond to infectious disease outbreaks.

In rethinking how the world must respond to disease outbreaks, the IHR emphasized the public health rationale of this international legal instrument. While public health was certainly important in previous versions, the IHR (2005) shifted away from a focus on controlling borders to one where containing diseases at their source was of paramount concern.⁷ For example, whereas the *Foreword* to the IHR (1969) noted that its purpose was “to ensure the maximum security against the international spread of diseases with a minimum interference with world traffic”,⁸ Article 2 of the IHR (2005) emphasizes “a public health response” as a central purpose of this international instrument.⁹ The protection of trade and travel remain important goals, but with the IHR (2005), the primacy of public health is clear.

In addition to clarifying the purpose and scope of this instrument, the revised IHR introduced a number of novel features that further privilege public health. In particular, the instrument’s scope was expanded beyond a specific list of diseases through the creation of the more holistic concepts such as “disease”, “event”, and “public health emergency of international concern” (PHEIC).¹⁰ Accompanying the creation of this new concept, the revised IHR also established specific procedures for countries to notify WHO of specific events. Using the IHR’s Annex 2 decision instrument, states parties are required to assess events that may constitute a PHEIC by focusing on four factors: the seriousness of the “public health impact of the event”; the nature of

4 IHR (2005), above n 1, 1.

5 Ibid.

6 Ibid, 1.

7 Sara E Davies et al., *Disease Diplomacy International Norms and Global Health Security* (2015) [hereinafter *Disease Diplomacy*].

8 International Health Regulations (1969) entered into force January 1, 1982, 5.

9 IHR (2005), above n 1, art 2.

10 Ibid., art 1, 12. See IHR Article 1 for the full definitions of “disease”, “event”, and “public health emergency of international concern”.

the event (“unusual or unexpected”); the “risk of international spread”; and the significance of the “risk of international travel and trade restrictions”.¹¹ The revised IHR give the WHO Director-General sole authority (albeit taking into consideration the advice of an expert group referred to in the Regulations as the “Emergency Committee”) to declare a PHEIC (Article 12) and to issue temporary recommendations that “may include health measures” to achieve the purpose and scope of the IHR (Article 15).¹²

Other features that support the public health goals of this instrument include: the creation of minimum core public health capacities (Articles 5, 13, and Annex 1) (discussed below); the expanded role of non-state actors in assisting with the detection of serious events by providing WHO with unofficial reports of public health events (Article 9); and the role of scientific evidence in decision-making processes (Article 12 for the PHEIC declaration, Article 17 for criteria for recommendations, Article 43 for additional health measures).

Having been absent in previous versions of the IHR, human rights also have a strong textual foundation in the revised IHR (2005), both as a protection for persons and travellers against measures that unnecessarily interfere with their liberties and as a fundamental principle for interpreting and implementing every aspect of this instrument, notably the universal right to health.¹³ Couched in mandatory language, Article 3 introduces the principles that must guide the implementation of the IHR, which “shall be with full respect for dignity, human rights and fundamental freedoms of persons” (Article 3.1) and “shall be guided by the Charter of the United Nations and the Constitution of the World Health Organization” as authoritative documents to provide further implementation guidance (Article 3.2).

The reference to the UN Charter and WHO’s Constitution provides key insights into how the IHR should be legally interpreted. Article 55 of the UN Charter requires the promotion of “universal respect for, and observance of, human rights and fundamental freedoms for all”, while the Constitution of the WHO recognizes “[t]he enjoyment of the highest attainable standard of health” as a fundamental right.¹⁴ In referring to these two texts, the IHR clarifies that human rights must be applied in the context of infectious disease control. By becoming a fundamental principle of the IHR, human rights became a tool to

11 Ibid, Annex 2.

12 Ibid, art 12, 15.

13 Ibid, 1, art 3, 32.

14 *Constitution of the World Health Organization*, open for signature 22 July 1946, 14 UNTS 185, (entered into force 17 November 1947) art 2(a) [WHO Constitution]. See Lawrence O Gostin, Benjamin M Meier, Rebekah Thomas, Veronica Magar, Tedros A Ghebreyesus, ‘70 Years of Human Rights in Global Health: Drawing on a Contentious Past to Secure a Hopeful Future’ (2018) *The Lancet* 2731–2735 <[http://dx.doi.org/10.1016/S0140-6736\(18\)32997-0](http://dx.doi.org/10.1016/S0140-6736(18)32997-0)>.

ensure effective pandemic preparedness and an interpretive aid in guiding the IHR's implementation.

National core public health capacities were also introduced in the IHR to strengthen countries' abilities to prevent, protect, control, and rapidly respond to potential health emergencies. Specifically, obligations were created for states parties to develop certain minimum core public health capacities within specific time frames, as articulated in Article 5, Article 13, and Annex 1.¹⁵ These core capacities, which did not exist in previous versions of the IHR, represent "an 'upstream' public health strategy to prevent and contain outbreaks at their source" and serve as a complement to the reaction-oriented procedures of the IHR.¹⁶

As noted earlier, a final fundamental addition to the IHR (2005) is Article 44 titled "Collaboration and Assistance" (Box 1). This article was introduced to create separate obligations on states parties to "undertake to collaborate with each other" and on WHO to "collaborate with States Parties", each "to the extent possible", on technical, logistical, financial, and legal aspects to ensure the success of the Regulations.¹⁷ Not only was collaboration not specifically required in earlier versions of the IHR, Article 44 was also absent in the first draft of the revised IHR circulated by the Intergovernmental Working Group (IGWG) that negotiated the revised text to regional and sub-regional country groups.¹⁸ It was introduced in the second draft of the revised IHR as a direct response to many countries' concerns about the feasibility of implementing core public health capacity requirements envisioned in the revised IHR without collaboration from other countries.¹⁹ (The details surrounding the addition of this article are further explored in **Section 3.2**)

The challenge is that, despite its inclusion in the legally binding IHR, most countries have not collaborated to the extent necessary, in particular, for achieving the minimum core public health capacities in every country.

Given this context, it is essential to bring clarity to the international legal obligations of states parties and WHO to collaborate and assist under Article 44 of the IHR. While certain elements of Article 44 are evident, there remain ambiguities within the article that have caused confusion and require clarification.

15 IHR (2005), above n 1, arts 5, 13, Annex 1.

16 Lawrence O Gostin & Rebecca Katz, "The International Health Regulations: The Governing Framework for Global Health Security" (2016) 94 *The Milbank Quarterly* 270 [hereinafter *The Governing Framework for Global Health Security*].

17 IHR (2005), above n 1, art 44.

18 International Health Regulations Working Paper for Regional Consultation, *Intergovernmental Working Group on Revision of the International Health Regulations*, Doc IGWG/IHR/Working paper/12.2003 (2004).

19 *Review and approval of proposed amendments to the International Health Regulations: Draft Revision*, Intergovernmental Working Group on Revision of the International Health Regulations, 11, Doc A/IHR/IGWG/3 (2004).

A shared understanding of what level and type of collaboration and assistance are legally required by the IHR is a necessary step in ensuring these obligations can be acted upon and fully realized. Without such clarity, it may be impossible for countries to know their exact obligations and to hold each other accountable for fulfilling them, thus undermining the public health purposes of the IHR.

To provide this clarity, public international law scholars specializing in global health were systematically identified and convened to collectively apply the interpretive framework of the *Vienna Convention on Law of Treaties* to the IHR, to reach a jurisprudential consensus on the legal meaning of obligations under Article 44, and author this consensus statement.²⁰ Twenty scholars were found to meet the following five criteria and were invited to a consensus conference: 1) public international law scholar; 2) qualified as a lawyer or appointed as a full-time core faculty at a law school; 3) focus at least half of one's scholarly activities on global health; 4) author of relevant peer-reviewed articles published within the last five years; and 5) independent of other scholars, supervisors, governments, and other directive entities. Fourteen scholars participated in the conference, held in Stellenbosch, South Africa, April 8–10, 2019, funded by research grants from the Canadian Institutes of Health Research and the Research Council of Norway. This “Stellenbosch Consensus” statement details the participating group's methodology and legal interpretation of Article 44 of the IHR. Some members of the expert group urged going further by specifying specific kinds and levels of transnational capacity building to fulfill their IHR legal obligations. Since no consensus could be reached on greater specificity, it does not appear in this collective statement.

2 Methodology

2.1 Preliminary comments

To clarify the obligations of collaboration created under Article 44 of the IHR, this analysis uses the rules of interpretation established in Articles 31 and 32

20 The Oxford Dictionary of Law defines “jurisprudence” as: “[t]he theoretical analysis of legal issues at the highest level of abstraction. Jurisprudence may be distinguished from both legal theory and the philosophy of law by its concern with those questions (e.g. about the nature of a particular right or duty, or a particular line of judicial reasoning) that arise within or are implied by substantive legal disciplines.” See Jonathan Law, *The Oxford Dictionary of Law* (Oxford University Press: Oxford, 2nd ed, 2018) *sub verbo* “jurisprudence”.

BOX 1 Article 44 of the IHR (2005)*Article 44 Collaboration and assistance*

1. States Parties shall undertake to collaborate with each other, to the extent possible, in:
 - a) the detection and assessment of and response to events as provided under these Regulations;
 - b) the provision or facilitation of technical cooperation and logistical support particularly in the development, strengthening and maintenance of the public health capacities required under these Regulations;
 - c) the mobilization of financial resources to facilitate implementation of their obligations under these Regulations; and
 - d) the formulation of proposed laws and other legal and administrative provisions for the implementation of these Regulations.
2. WHO shall collaborate with States Parties, upon request, to the extent possible, in:
 - a) the evaluation and assessment of their public health capacities in order to facilitate the effective implementation of these Regulations;
 - b) the provision or facilitation of technical cooperation and logistical support to States Parties; and
 - c) the mobilization of financial resources to support developing countries in building strengthening and maintaining the capacities provided for in Annex 1.
3. Collaboration under this Article may be implemented through multiple channels, including bilaterally, through regional networks and the WHO regional offices and, through intergovernmental organizations and international bodies.

of the 1969 *Vienna Convention on the Law of Treaties* (Vienna Convention).²¹ Although the rules of the *Vienna Convention* do not represent an exhaustive compilation of guidance on the interpretation of international agreements, they are widely regarded as having general applicability to the interpretation of international legal instruments as an expression of accepted principles and practices, including instruments like the IHR that were concluded under the

21 *Vienna Convention on the Law of Treaties*, opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980). [hereinafter *Vienna Convention*].

auspices of an international organization.²² Support for this latter conclusion can be found under Article 5 of the *Vienna Convention* which stipulates that “the Convention applies...to any treaty adopted within an international organization without prejudice to any relevant rules of the organization”.²³ While the IHR is not referred to as a “treaty” by WHO or its parties, the *Vienna Convention* was nonetheless applied here because it is the most authoritative framework for interpreting all types of written international law instruments no matter their name or label.

Regulations adopted under Article 21 of the WHO Constitution become legally binding on all WHO member states unless a state expresses its wish to be exempt within 18 months from the date of notification.²⁴ Since no state party had sought to opt out of the revised IHR before its entry into force, the IHR is binding on all these states, with two additional states, the Holy See and Liechtenstein, acceding subsequently.

The degree to which states understood the IHR to create reciprocal legal obligations subject to the Vienna Convention is further illustrated by the responses that emerged from reservations to the regulations. For example, speaking on behalf of 27 member states, Portugal, as then-President of the Council of the European Union, recalled the principle set out in Article 27 of the Vienna Convention that “a Party may not invoke the provisions of its internal law as justification for its failure to perform its international obligations” and concluded that federal governments would be expected to “exercise every effort to ensure that the provisions of the IHR are fully implemented and given full effect by the pertinent authorities”.²⁵

2.2 *Interpretative approach: Framework*

The UN International Law Commission (ILC) has previously advised that the interpretation of a treaty should consist of “a single combined operation, which places appropriate emphasis on the various means of interpretation indicated, respectively, in articles 31 [general rule of interpretation] and 32 [supplementary means of interpretation]” (*emphasis added*) of the *Vienna Convention*.²⁶ Guided by the authority of the ILC, the analysis in this article uses the means

22 Richard K Gardiner, *A Single Set of Rules* (Oxford University Press, Oxford, UK, 2nd ed, 2015).

23 *IHR (2005)*, above n 1, art 5.

24 *WHO Constitution*, above n 14, art 22.; *IHR*, above n1, art 59(1).

25 *IHR (2005)*, above n 1, appendix 2.

26 International Law Commission, *Chapter VI Subsequent agreements and subsequent practice in relation to the interpretation of treaties* (New York: United Nations, 7th session, 2018) 11 at 13 [hereinafter *2018 ILC Report*].

of interpretation found in Articles 31 and 32 of the *Vienna Convention*. The following section outlines the different aspects of Articles 31 and 32, emphasizing which means of interpretation are most helpful for the understanding of the IHR's Article 44.

2.2.1 General rule of interpretation: Ordinary meaning

As a starting point, Article 31.1 of the *Vienna Convention* requires a "good faith" interpretation of the "ordinary meaning given to the terms of the treaty" within the "context" and in light of the treaty's "object and purpose".²⁷ The context and object and purpose are necessary to understanding an ordinary meaning and should not be considered as "additional or optional elements" when undertaking an interpretation under Article 31.1.²⁸

With regard to the "context" necessary for an ordinary meaning interpretation under Article 31.1, Article 31.2 clarifies that this refers to the "text, including its preamble and annexes", as well as other agreements "made between all the parties in connexion with the conclusion of the treaty", or other instruments "made by one or more parties in connexion with the conclusion of treaty and accepted by the other parties as an instrument related to the treaty".²⁹ The analysis that follows relies only on the whole text (including the preamble and annexes), as there are no additional relevant agreements or other instruments made in connection to the conclusion of the IHR (2005) that aid in interpreting Article 44.

2.2.2 General rule of interpretation: Subsequent agreements and subsequent practice

Article 31.3 establishes further tools to use under the general rule of interpretation: subsequent agreements and subsequent practice. The first – "(a) subsequent agreements between the parties regarding the interpretation or application of the treaty and its provisions"³⁰ – does not apply as none have been made in connection with Article 44 of the IHR.

The second – (b) "subsequent practice in the application of the treaty which establishes agreement on its interpretation"³¹ – is of limited applicability in the case of interpreting Article 44. In order to determine whether a state's action qualifies as "practice" under the Vienna Convention, the threshold test

²⁷ *Vienna Convention*, above n 21, art 31.1.

²⁸ Richard K Gardiner, *The Vienna Convention Rules on Treaty Interpretation* (Oxford University Press, Oxford, UK, 2nd ed, 2015) 482 [hereinafter *Treaty Interpretation*].

²⁹ *Vienna Convention*, above n 21, art 31.2.

³⁰ *Ibid*, art 31.3(a).

³¹ *Ibid*, art 31.3(b).

requires establishing that the practice reflects an agreement of the parties that has been carried out “systematically or repeatedly in implementation and application of a treaty”.³² The ILC *Draft conclusions on subsequent agreement and subsequent practice in relation to the interpretation of treaties* affirms that subsequent practice is “an authentic means of interpretation under article 31, paragraph 3(b)” and that it “consists of conduct in the application of a treaty, after its conclusion, which establishes the agreement of the parties regarding the interpretation of the treaty”.³³ The ILC report also specifies that “the weight of a subsequent agreement or practice as a means of interpretation under article 31, paragraph 3, depends, *inter alia*, on its clarity and specificity” and that the weight of a subsequent practice depends on “whether and how it is repeated”.³⁴

This threshold for the application of subsequent practice to aid in the interpretation of a treaty is very high.³⁵ The authors agreed that, for the purposes of understanding Article 44 of the IHR, there is no state practice that meets the *Vienna Convention's* Article 31.3 requirements. Instead, Section 4 presents “state action” as empirical observations of what practically occurs in terms of collaboration for global health security. Although not an authoritative interpretative tool under the *Vienna Convention*, these practices could provide initial evidence of what action could qualify as collaboration under Article 44.

2.2.3 General rule of interpretation: Relevant and applicable rules of international law

The third, yet equally important, element to be taken into account under Article 31.3(c) calls for consideration of “any rules of international law applicable to the relations between parties”.³⁶ In other words, the provision refers to the principle of *systemic integration*, “whereby international obligations are

32 Richard Gardiner, ‘The General Rule: (2) Agreements as Context, Subsequent Agreements, and Subsequent Practice’ in *Treaty Interpretation*, (Oxford University Press, Oxford, UK, 2nd ed, 2015) 254.

33 ILC *Draft conclusions on subsequent agreement and subsequent practice in relation to the interpretation of treaties*.

34 International Law Commission, ‘Chapter VI Subsequent agreements and subsequent practice in relation to the interpretation of treaties’ in *Report on the Work of the Seventieth Session* Doc. A/CN.4/L.917 + Add.1 (New York: United Nations, 2018) 11 at 70.

35 International Law Commission, ‘Chapter IV Subsequent agreements and subsequent practice in relation to the interpretation of treaties’ in *Report on the Work of the Sixty-fifth Session* A/CN.4/L.819 + Add.1–3 (New York: United Nations, 2013) 11 at 30.

36 *Vienna Convention*, above n 21, art 31.3(c).

interpreted by reference to their normative environment”.³⁷ As expressed by the International Law Commission’s Study Group on the Fragmentation of International Law, Article 31(3)(c) requires “the integration into the process of legal reasoning – including reasoning by courts and tribunals – of a sense of coherence and meaningfulness”.³⁸

According to international legal scholars, the terms of this clause operationally allow for obligations emerging from other binding international legal agreements which apply to the parties of a treaty under interpretation to be considered as part of the “relevant rules of international law applicable to the relations between parties”.³⁹ The ICJ confirmed this approach in *Djibouti v France* (2008), a case in which Djibouti successfully supported its claim that France had violated its obligations for mutual assistance under the 1986 *Convention on Mutual Assistance in Criminal Matters* by referring to a 1977 bilateral treaty which required the two countries to found their relations on equality, mutual respect, and peace.⁴⁰

This interpretative tool is primarily used in **Section 3.2.2** of this analysis, which examines the normative environment surrounding the IHR with respect to international human rights law in order to provide one explanation for the centrality of core capacities within an interpretation of Article 44.

2.2.4 General rule of interpretation: special meaning

The last general rule of interpretation (Article 31.4) is that “special meaning shall be given to a term if it is established that the parties so intended”.⁴¹ While Article 1 of the IHR lays out specific definitions necessary for understanding this instrument, none are specific to, or aid in the interpretation of Article 44. This analysis therefore does not rely on Article 31.4 of the *Vienna Convention*.

2.2.5 Supplementary means of interpretation

Lastly, Article 32 of the *Vienna Convention* dictates that “[r]ecourse may be had to supplementary means of interpretation” for two different purposes.⁴²

37 UNGA, International Law Commission, *Report of the Study Group of the International Law Commission*, 58th Sess, UN Doc A/CN.4/L.682 (13 April 2006) [413] [*ILC Study on the Fragmentation of International Law*].

38 *Ibid*, [419].

39 Richard K Gardiner, *The General Rule: (3) Relevant Rules of International Law and Special Meanings* (Oxford University Press, Oxford, UK, 2nd ed, 2015) 301.

40 *Certain Questions of Mutual Assistance in Criminal Matters (Djibouti v France)*, (*Judgment*), [2008] ICJ Rep 177, 219.

41 *Vienna Convention* above n 21, art 31.4.

42 *Ibid*, art 32.

Recourse to supplementary means of interpretation may be made to confirm the meaning determined through the application of the general rule of interpretation in Article 31.⁴³ Supplementary means may also be used to determine the meaning where the general rule of interpretation leaves the meaning either ambiguous or obscure, or would otherwise lead to manifestly absurd or unreasonable interpretation.⁴⁴ Supplementary means, which include the treaty's preparatory work, are rarely determinative and are more commonly deployed to support interpretations achieved under Article 31.⁴⁵

Supplementary means of interpretation are used throughout this analysis of Article 44 to confirm the interpretation reached by the ordinary meaning within the context of the IHR, and in light of the IHR's object and purpose. This analysis utilizes summary documentation related to the *travaux préparatoires* – including Secretariat reports, IGWG documents, and regional reports made publicly available by WHO – as supplementary means of interpretation.

3 Interpreting Article 44

Recognizing the importance of interpreting Article 44 of the IHR (2005), the following section uses the general rule of interpretation in Article 31 of the *Vienna Convention* to determine the ordinary meaning, while supporting the ordinary meaning with the context, and object and purpose in a “single combined operation”.⁴⁶ Where appropriate, recourse is made to supplementary means, as defined by Article 32 of the *Vienna Convention*, to confirm an interpretation reached under the general rule.

3.1 *Obligations*

Article 44 creates a legally binding duty on states parties and WHO: 1) states parties “shall undertake to collaborate”; and 2) WHO “shall collaborate”.⁴⁷ The use of this imperative verb “shall”, rather than weaker language such as “should”, indicates the existence of a legal obligation. The decision to include imperative language in Article 44 is evidence of the intention of creating a legally binding duty.

43 Ibid.

44 Ibid.

45 *Treaty Interpretation*, above n 28, 489.

46 *Vienna Convention* above n 21, art 31; *2018 ILC Report*, above n 26, 13.

47 *IHR (2005)*, above n 1, art 44.

“Collaboration” is defined as “a cooperative agreement of two or more parties to work jointly towards a common goal”.⁴⁸ Interestingly, while the title of Article 44 encompasses the two concepts of “collaboration” and “assistance”, the article itself only outlines the various ways states parties and WHO can collaborate and does not refer to “assistance” when elaborating on the duties. The absence of “assistance” within the body of the article indicates that Article 44 is primarily about how states parties and WHO can work jointly to achieve IHR’s goals through collaboration. The analysis that follows will therefore only refer to obligations of “collaboration”.

A granular examination of Article 44.1 (states parties) and Article 44.2 (WHO) provides insight into the obligations that can be gleaned from an interpretation of this article. In doing so, it also becomes evident what aspects of collaboration cannot be determined based on a *Vienna Convention* interpretation of this article.

3.1.1 Article 44.1: States parties

States parties are the first duty-bearers under Article 44.1, which dictates that states parties “shall undertake to collaborate with each other, to the extent possible”.⁴⁹ Article 44 applies to all states parties to the IHR, as none made successful reservations specifically with respect to this article.⁵⁰ The following textual analysis reveals that Article 44.1 creates a common and shared responsibility among all states parties to collaborate towards the achievement of four key areas, with a particular focus on the core public health capacities identified in the IHR, and that, although Article 44.1 does not specify how states parties can implement their individual obligations, there are clearly different levels and types of collaboration expected from different countries.

Before delving into the various ways states parties can collaborate with each other, it is useful to articulate that collaboration under Article 44 does not displace individual state obligations under the IHR but instead must be read as a supplement to these individual obligations. The IHR creates many immediate duties that each country must achieve in order to fulfill all their obligations. For example, Article 5.1 dictates that states parties “shall develop, strengthen, and maintain, as soon as possible but no later than five years from the entry into force [...] the capacity to detect, assess, notify and report events”.⁵¹ Article

48 BLACK’S LAW DICTIONARY, Definition of *Collaboration* (March 17, 2018) <<https://thelawdictionary.org/collaboration/>>.

49 IHR (2005), above n 1, art 44.1.

50 WHO, *States Parties to the International Health Regulations (2005)* (November 16, 2018) <http://www.who.int/ihr/legal_issues/states_parties/en/>.

51 IHR (2005), above n 1, art 5.1.

13.1 creates similar obligations on states parties to develop “the capacity to respond promptly and effectively” to PHEICs.⁵² While Article 44.1 places obligations on states parties to collaborate with other states parties, an understanding of the IHR as a whole confirms that states must first mobilize their own resources to meet their obligations. The presence of Article 44 does not excuse inaction on the part of individual countries, but instead must be read in light of all obligations placed on individual states in the IHR.

Article 44.1 lists four possible areas for state parties to collaborate in fulfillment of their collaboration obligations. First, states parties must undertake to collaborate in the detection, assessment of, and response to events (Article 44.1(a)). Second, collaboration must occur in the provision of technical cooperation, logistical support, and the mobilization of financial resources, with a specific mandate for “the development, strengthening and maintenance of the public health capacities required under these Regulations” (Article 44.1(b)).⁵³ Third, states parties are charged with a general duty to mobilize financial resources “to facilitate implementation of their obligations under these Regulations” (Article 44.1(c)).⁵⁴ Fourth, states parties must undertake to collaborate in formulating laws and other legal and administrative provisions (Article 44.1(d)).⁵⁵ Examples of each of these elements are explored in **Section 4**.

Despite the fact that all states have a common and shared responsibility to collaborate, Article 44 provides flexibility as to how its obligations can be fulfilled. Specifically, the language and structure of Article 44 acknowledges the possibility of differentiated duties among states depending on experience and resources. The clause “to the extent possible”, followed by a list of four areas requiring attention, indicates that different states parties are expected to fulfill their obligations in varying ways. States parties with one or more of the four capabilities listed in Article 44.1 – technical, logistical, financial, and/or legal or administrative – will collaborate depending on what their capacities allow them to contribute towards achieving the IHR’s goals. **Section 3.3** explores the possible limits to this flexibility.

There was, however, no consensus among the authors on whether Article 44 mandates how countries should implement their individual obligations pursuant to the common and shared responsibility. Article 44.1 indicates that duties of collaboration will not necessarily be fulfilled in the same manner by each

52 Ibid, art 13.1.

53 Ibid, art 44.

54 Ibid, art 44.1.

55 Ibid.

country but does not provide information on how exactly a specific state party will determine its individual duty.

3.1.2 Article 44.2: WHO

Article 44.2 outlines the obligations required by WHO, which “shall collaborate with States Parties, upon request, to the extent possible”.⁵⁶ Despite the differences in the obligations of states parties to “undertake to collaborate” and WHO to simply “collaborate”, there is overlap between both duty-bearers’ substantive obligations.

WHO must collaborate in the evaluation and assessment of countries’ public health capacities (Article 44.2(a)), on the “provision or facilitation of technical cooperation and logistical support to states parties” (Article 44.2(b)), and mobilizing financial resources “to support developing countries in building, strengthening and maintaining the capacities provided in Annex 1” (Article 44.2(c)). With regard to financial mobilization, WHO has a narrower duty to specifically work with developing countries in creating core public health capacities for surveillance and response (Annex 1A) and for designated airports, ports, and ground crossings (Annex 1B).

WHO’s responsibilities to collaborate are further specified within the broader context of the IHR. Articles 5 and 13 on core capacities for surveillance and for public health responses reiterate WHO’s duties to “assist States Parties upon request, to develop, strengthen and maintain the capacities referred to in paragraph 1 of this Article” (Article 5.3). Articles 5 and 13 also state WHO’s duties to “collaborate in the response to public health risks and other events by providing technical guidance and assistance and by assessing the effectiveness of the control measures in place, including the mobilization of international teams of experts for on-site assistance, when necessary” (Article 13.3). Articles 5, 13, and 44 all require collaboration from WHO.

Article 44.2 also dictates that WHO’s duty to collaborate is triggered “upon request” by states parties to the organization. This clause was added to the final version of the IHR, likely in response to countries’ concerns raised in the regional consultations over the need to balance sovereignty of states parties and WHO’s mandate under the IHR.⁵⁷ Interestingly, the French, Spanish, and Chinese versions – equally as authoritative as the English version – do not include this clause.

The limits imposed by “to the extent possible” are explored in **Section 3.3**.

56 Ibid, art 44.2.

57 *Summary Report of Regional Consultations, Intergovernmental Working Group on Revision of the International Health Regulations, Doc A/IHR/1GWG/2 (2004) ¶ 8, 12, [hereinafter *Summary Regional Consultations*].*

3.1.3 **Article 44.3: Implementation of the obligation to collaborate**
 Article 44.3 gives states parties and WHO flexibility on the mechanisms for discharging their duties under Article 44. Collaboration “may be implemented” using bilateral or regional networks, WHO regional or country offices, or inter-governmental organizations and international bodies.⁵⁸ The use of “may” indicates that states parties and WHO have the discretion, but are not obligated, to use these channels to fulfil their respective obligations under Article 44.1 and 44.2. Although states parties and WHO may collaborate through these channels, the legal duty required by Article 44 remains on each state party to engage with each other and with third parties.

The context of the IHR as a whole, and in light of the constitutional functions of the organization listed in Article 2 of the WHO Constitution, the IHR places greater expectations on WHO to collaborate with third parties. Article 14 creates a legally binding obligation on WHO whereby WHO “shall cooperate and coordinate its activities, as appropriate with other competent intergovernmental organizations or international bodies in the implementation of these Regulations [...]”.⁵⁹ Resolution WHA 58.3 of the World Health Assembly – WHO’s plenary governing body which adopted the IHR in 2005 pursuant to the organization’s constitution – includes a list of eleven organizations and bodies with which WHO is expected to collaborate to fulfill its duties under Article 14 of the IHR (2005).⁶⁰ The resolution requests that the WHO Director-General work with these organizations to achieve the IHR’s goals.⁶¹

3.2 *Centrality of core capacities*

Although the scope of collaboration in Article 44 is intended to target multiple aspects of the IHR, the core public health capacities required of each country by Articles 5, 13, and Annex 1 represent a priority area for collaboration. There are two main rationales for linking the minimum obligations required by Article 44 to the public health capacities listed within the text of the IHR: a public health rationale, and a human rights rationale. While neither rationale is definitive on its own, they each provide an understanding for why core

58 *IHR (2005)*, above n 1, art 44.3.

59 *Ibid*, art 14.

60 The listed organization are: United Nations, International Labour Organization, Food and Agriculture Organization, International Atomic Energy Agency, International Civil Aviation Organization, International Maritime Organization, International Committee of the Red Cross, International Federation of Red Cross and Red Crescent Societies, International Air Transport Association, International Shipping Federation, and Office International des Epizooties, Also see above n 1, 4.

61 *IHR (2005)*, above n 1, 4.

capacities are important not only for the realization of Article 44, but for IHR obligations as a whole.

3.2.1 Public health rationale

Core capacities hold a central role in the IHR's public health response and are therefore a key target for collaboration under Article 44. The importance of the core capacities is principally highlighted in Part II of the IHR ("Information and Public Health Response") in conjunction with Annex 1, which outlines the capacities necessary for surveillance (Article 5) and for responding to PHEICs (Article 13).⁶² Annex 1 outlines the minimum core public health capacities required at the local/primary level, the intermediate level (regional or provincial), and at the national level, which include laboratories, human resources, surveillance, preparedness, response, risk communication, coordination, designation of a National IHR Focal Point, legislation, policy, and financing.⁶³ All these capacities are necessary to achieve the IHR's overall public health goals of preventing, protecting against, and controlling the international spread of infectious diseases.

Described as "an indisputable baseline for global health security",⁶⁴ the core public health capacities are also necessary to achieve other key obligations required by both states parties and WHO under the IHR. From the perspective of states parties, core capacities are required to discharge duties of surveillance (Article 5), notification to WHO within 24 hours of assessment of a public health event (Article 6), information-sharing of unexpected or unusual events (Article 7), information-sharing to WHO within 24 hours of receipt of evidence of public health risks identified outside a country's territory (Article 9.2), and of verification and provision of information to WHO in relation to "other sources" (Article 10.2).⁶⁵ Further, without a surveillance system capable of detecting events, states parties will be unable to use the Annex 2 Decision Instrument to make a proper determination of when an event should be notified to WHO.⁶⁶

Strong core public health capacities within every state party are also necessary for WHO to fulfill its obligations. For example, without the timely detection and receipt of information, WHO will struggle to provide states parties and appropriate intergovernmental organizations the public health information "necessary to enable States Parties to respond to a public health risk"

62 Ibid, art 5, 13, Annex 1.

63 Ibid, Annex 1; *The Governing Framework for Global Health Security*, above n 16, 269.

64 *The Governing Framework for Global Health Security*, above n 16, 276.

65 *IHR (2005)*, above n 1.

66 Ibid, Annex 2.

(Article 11.1).⁶⁷ Most importantly, without states parties' capabilities to provide WHO with accurate and timely information, WHO's Director-General will be severely handicapped in making PHEIC determinations (Article 12).

The importance of the core capacities is also highlighted by the time-bound nature of these obligations and by the assessment requirements imposed on states parties. Article 5 (surveillance) and Article 13 (public health response) both require that the capacities be achieved "as soon as possible but no later than five years from the entry into force" of the IHR.⁶⁸ States parties were equally required to, within two years of the IHR's entry into force, assess "the ability of existing national structures and resources to meet the minimum requirements described in this Annex".⁶⁹ Creating a time-limit for these elements of the IHR underscores an understanding that core capacities were critical to the achievement of the revised IHR's purpose of preventing, protecting against, controlling, and providing a public health response to the international spread of disease (Article 2).

The above textual interpretation is supported by recourse to supplementary documentation. The WHO Secretariat's supplementary documents on the drafting history of the IHR confirm this understanding that core capacities are central to the public health goals of the IHR and therefore also to an interpretation of Article 44. Not only was there widespread support for the "overall direction and approach of the proposals for the revision", which would help with "detection of threats to international public health, response and management of these threats to international public health, and communications among national institutions and between Member States and the Secretariat",⁷⁰ but many understood that existing capacities would need to be strengthened "in order to implement fully and successfully the revised Regulations".⁷¹

While the full challenge of implementing IHR obligations may have originally been underestimated, many states parties flagged during the initial consultation process, that compliance with some of the resource-intensive obligations (i.e., the core capacities) would be problematic and would therefore hamper their ability to fulfill obligations created in the IHR. To respond to the concerns about the feasibility of compliance, the WHO Secretariat suggested adding Article 44 to the second revised draft (September 2004).⁷² The WHO

67 Ibid, Annex 2, art 11.1.

68 Ibid, Annex 2, art 5, 13.

69 Ibid, Annex 1.

70 *Summary Regional Consultations*, above n 57, 4.

71 Ibid [5].

72 *Review and Approval of Proposed Amendments to the International Health Regulations: Draft Revision, Intergovernmental Working Group on Revision of the International Health Regulations*, Doc A/IHR/IGWG/3 (2004).

Secretariat indicated in an explanatory note that this article was “in response to several comments requesting that the draft revision should clearly provide the possibility for state parties to collaborate with each other in a number of areas related to the implementation of the Regulations” (Article 44.1) and “introduced to specify WHO’s commitment to collaborate with States Parties in the implementation of the Regulations” (Article 44.2).⁷³ Although not determinative, these supplementary documentations indicate that Article 44 was intimately linked to core capacities, and helps support a textual interpretation of the importance of core capacities to support the public health goals of the IHR.

Without core capacities, states parties and WHO require more time to detect and respond to an event, leading to more lives lost and ultimately preventing the world from achieving the public health objective and purpose of the IHR.⁷⁴ Public health is therefore the first rationale for the primacy of core capacities.

3.2.2 Human rights rationale

The centrality of core capacities is also supported by the existence of human rights obligations. Using the *systemic integration* method found in Article 31.3(c) of the *Vienna Convention*, the IHR can be linked to similar obligations found within the *International Covenant on Economic, Social and Cultural Rights* (ICESCR). Specifically, similar to Article 44 of the IHR, Article 2.1 of the ICESCR requires that international assistance and co-operation form part of how rights within the treaty are realized. The IHR can also be linked to Article 12.2(c) of the ICESCR, which creates obligations for the control of infectious diseases. There is synergy not only between the ICESCR and the IHR as a whole but, taken together, these obligations under the IHR and ICESCR provide a further rationale for the primacy of the core capacities when deciphering the scope of collaboration under Article 44 of the IHR.

Although only one component of the commitments made by states parties to the full realization of the right to health, Article 12.2(c) of the ICESCR establishes that realizing the right to health requires that steps be taken for “the prevention, treatment and control of epidemic, endemic, occupational and other diseases”.⁷⁵ Commitments to this element of the right to health are further

73 *Review and Approval of Proposed Amendments to the International Health Regulations: Explanatory Notes, Intergovernmental Working Group on Revision of the International Health Regulations*, Doc A/IHR/IGWG/4 (2004).

74 *The Governing Framework for Global Health Security*, above n 16, 276.

75 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976).

elaborated on in General Comment No. 14 adopted by the UN Committee on Economic, Social and Cultural Rights, which establishes that, under the right to health's core obligations, "measures to prevent, treat and control epidemic and endemic diseases" are considered "obligations of comparable priority" to the core obligations identified by the Committee.⁷⁶ General Comment No.14 also outlines what the fulfillment of this subsection of the right entails: disease control under Article 12.2(c) includes efforts to "make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control".⁷⁷

The IHR, an instrument focused on the prevention and control of the international spread of diseases and guided by human rights principles, provides an avenue through which countries can fulfill part of their obligations to progressively realize the right to health under the ICESCR and related human rights instruments. The obligations for disease control created under the ICESCR, coupled with details in General Comment No. 14 on what achievement would entail, mirror the IHR core capacities required by Articles 5, 13, and Annex 1.⁷⁸ Even though the IHR only targets one aspect of the right to health under Article 12, the commitments made by states parties under the IHR are essential to the realisation of a key part of the right to health for individuals within their borders and in other countries, as enumerated in treaty text and elaborated in authoritative interpretation. Although the core capacities are only one aspect for the proper implementation of the IHR as a whole, they are in alignment with states parties' existing obligations under the ICESCR. Core capacities under the IHR are essential to not only achieve the IHR's public health goals, but to also achieve part of the right to health under the ICESCR.

3.3 *Flexibilities and limitations on flexibilities*

As noted above, Article 44 creates an obligation for shared responsibility of collaboration to achieve the goals of the IHR. The clause "to the extent possible" however, introduced the idea that there are limitations to this obligation. While "to the extent possible" can be interpreted as providing flexibility and leeway on the level, type, and scope of collaboration that must be undertaken, a strict legal interpretation does not reveal the exact extent and meaning of

⁷⁶ Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, U.N. Doc E/C.12/2000/4 (August 11, 2000) [40]. [hereinafter *General Comment 14*].

⁷⁷ *Ibid.*, [16].

⁷⁸ *IHR*, above n 1, art 5, 13, Annex 1; ICESCR, above n 76, art 12; *General Comment 14*, above n 77, [16], 44.

these limitations. It was agreed that the clause does not create an unlimited discretion for states parties and WHO to determine the nature of their obligations. While the concise phrasing of Article 44 prevents an exact interpretation of these flexibility's limitations, there are certain limitations that can be interpreted from the context, and object and purpose, and supported by supplementary means of interpretation.

Although "to the extent possible" introduces flexibility into Article 44, it must be read within the context of the obligation created by "shall". Other language could have been used to indicate greater discretion: "should" or "may" could have been used to indicate authoritative albeit non-binding advice; "may" could have been used to allow for a discretionary provision. The language of Article 44 supports an understanding that every state is bound by the mandatory obligations to achieve at least a certain level of collaboration necessary to achieve the object and purpose of the IHR.

As noted above, the IHR is primarily a public health instrument with a focus on the prevention, protection against, and control of the international spread of disease.⁷⁹ Given the transboundary nature of infectious and other diseases, the safety of individuals around the world requires a certain level of cooperation among states because, when faced with a disease outbreak, in particular a PHEIC, the world may only be as strong as its weakest link. The world is more vulnerable when some states parties are not able to fully implement the IHR. Even if a country has achieved all of the core public health capacities identified in the IHR, it will still be vulnerable if neighbouring or travel-hub countries do not have sufficient capacities to detect and contain a potential outbreak. Given the importance of the legally binding IHR for global health security, it would be unreasonable if perhaps the most critical component of this instrument (i.e. the core capacities) was undermined by the fact that some countries could not meet their obligations and other countries did not have an obligation to collaborate with them in achieving these obligations. The public health purpose of the IHR therefore requires that the limitations imposed by "to the extent possible" are not unlimited. Indeed, the spirit of the regulations could be understood to require a more robust cross-national collaboration and capacity building.

This interpretation that the IHR's collaboration obligations cannot be completely discretionary is supported by supplementary means of interpretation. While not determinative alone for an interpretation of the limitation, the preparatory work makes clear that Article 44 was intended to create at least a

79 *IHR*, above n 1, art 2.

meaningful level of cooperation among states in order to ensure that implementing the IHR, and the core capacities in particular, was feasible.

Article 44 and its preparatory materials therefore confirm an interpretation that “to the extent possible” does not create an unlimited flexibility. While this ordinary meaning interpretation, confirmed by the supplementary means of interpretation, does not allow us to decipher the exact limits of this flexibility, Part IV provides examples of this flexibility that may begin to provide some sense of these limits.

4 Examples of Collaboration

As noted in Section 2.2, in the case of Article 44, there does not exist “subsequent practice in the application of the treaty which establishes the agreement of the parties regarding its interpretation”.⁸⁰ While there does not yet exist consistent and explicit practice on collaboration that meets this high threshold, there is evidence of how collaboration under Article 44 of the IHR could be achieved. During the consensus conference deliberations, the scholars agreed to refer to this practice as “state action”. The following provides a non-exhaustive elaboration of how Article 44 provides flexibility for different states parties and WHO to fulfill their obligations of collaboration. While they are not authoritative under the *Vienna Convention*, they provide helpful examples of actual instances of practice that can also be seen as a form of implementation of Article 44 obligations.

4.1 State Action

4.1.1 Article 44.1(a): Detection and assessment of, and response to, events

First, certain states parties may be better placed to collaborate in the “detection and assessment of, and response to, events”.⁸¹ For example, by the very nature of a virus originating in a specific geographic area, sharing samples of viruses that have the potential to instigate a PHEIC may only be possible for states in which the virus is uniquely available. Sharing virus samples with other countries is an interesting example of collaboration because it is applicable to all countries, no matter their economic status. It is a valuable form of collaboration because it allows the world to use its collective resources to create possible vaccines or medical devices that will protect the world against the

⁸⁰ *Vienna Convention*, above n 21, art 31.3(b).

⁸¹ *IHR*, above n 1, art 44.1(a).

particular strain of the virus and could be vital in preventing the spread of a disease. Sample sharing for influenza is subject to the *Pandemic Influenza Preparedness Framework* (PIP Framework), a normative framework that aims to create a balance between maintaining strong global influenza surveillance and response systems while also ensuring equitable access to resulting benefits.⁸² The kind of virus sample sharing anticipated in the PIP Framework for pandemic influenza could additionally be undertaken as part of the IHR's Article 44 collaboration obligations for other diseases.

4.1.2 Article 44.1(b): Technical cooperation and logistical support

Other states parties may be particularly equipped to collaborate in certain aspects of responding to events or in providing logistical support in the event of a PHEIC.⁸³ Uganda's actions during the 2014–2016 Ebola outbreak in West Africa exemplify how a country can provide logistical collaboration to other countries during an outbreak. Uganda is a low-income country that, through its own experiences with Ebola between 2000 and 2012, developed logistical capacities for health workers to respond to the disease.⁸⁴ Uganda sent its trained health workers to Guinea, Liberia, Nigeria, and Sierra Leone in 2014 to support “clinical management, coordination, surveillance, laboratory and social mobilization components of the response”.⁸⁵ Uganda had access to capacities that other countries in the area, whether low-, middle- or high-income, did not possess, and was able to share these capacities during a critical time.

Canada also provided logistical support in responding to the Ebola outbreak in West Africa. In 2014, Canada donated 800 vials of an experimental Ebola vaccine its scientists had developed to WHO so that the vaccine could be made available as an international resource.⁸⁶ Further, Canada provided personal protective equipment, which included 500,000 N95 respirators, 1,500,000 examination gloves, 3,500 surgical gloves, 50 hooded coverall suits, 2,100,000 face

82 WHO, *PANDEMIC INFLUENZA PREPAREDNESS FRAMEWORK FOR SHARING OF INFLUENZA VIRUSES AND ACCESS TO VACCINES AND OTHER BENEFITS*, (2011) <https://www.who.int/influenza/pip/PIP_FQA_Nov_2011.pdf>.

83 IHR above, n 1, art 44.1(b).

84 WHO, *UGANDA HEALTH WORKERS SUPPORTING WEST AFRICA ON EBOLA RESPONSE* (15 August 2014) <<https://afro.who.int/news/uganda-health-workers-supporting-west-africa-ebola-response>>.

85 Ibid.

86 GOVERNMENT OF CANADA, *FACT SHEET – VSV-EBOV – CANADA'S VACCINE FOR EBOLA* (2018) <<https://www.canada.ca/en/public-health/services/infectious-diseases/fact-sheet-ebov-canada-s-experimental-vaccine-ebola.html>>.

shields, and 1,250,000 isolation gowns.⁸⁷ A mobile lab was also sent to Sierra Leone for rapid testing.⁸⁸ Uganda and Canada's experiences demonstrate that collaboration in responding to events can manifest itself in different forms and that logistical cooperation, as required under Article 44.1(b), could be expected from all states parties depending on their specific expertise, resources, and circumstances.

4.1.3 Article 44.1(c): Mobilization of financial resources

Financial support is also required to implement obligations under the IHR. In addition to Article 44.1(c) specifically dictating that collaboration is required to mobilize financial resources, many aspects of the provision of technical cooperation, logistical support, and administrative or legal support, will also require collaboration around financial resources.

The response of the Economic Community of West African States (ECOWAS) during the 2014 Ebola outbreak provides an example of "state action" around the mobilization of financial resources. In the midst of the outbreak, ECOWAS created a "Solidarity Fund" to pool together resources to enable prompt response to public health emergencies including Ebola.⁸⁹ Financial contributors included Benin, Cape Verde, Cote d'Ivoire, Niger, Nigeria and Togo, for a total of USD 5,684,409.⁹⁰

4.1.4 Article 44.1(d): Formulation of proposed laws and other legal/administrative provisions

The fourth area for collaboration is legal and administrative reform.⁹¹ As national legislation and regulations are important for institutionalizing and strengthening the role of the IHR, states parties have an opportunity to collaborate with others to reach these goals. Through the Global Health Security Agenda (GHSa), a partnership of states that uses a multilateral and multi-sectoral approach to help build countries' capacity to prevent, detect, and respond to threats from infectious diseases,⁹² the Joint External Evaluation (JEE)

87 GOVERNMENT OF CANADA, *CANADA'S RESPONSE TO THE EBOLA OUTBREAK IN THE WEST AFRICA REGION* (2014) <<https://www.canada.ca/en/news/archive/2014/09/canada-response-ebola-outbreak-west-africa-region.html>>.

88 Ibid.

89 ECONOMIC COMMUNITY OF WEST AFRICAN STATES (ECOWAS), *The Ebola: The fight against epidemic of the Ebola virus disease within ECOWAS* <">https://www.ecowas.int/ebola/#_Toc411933801>.

90 Ibid; Nigeria: lower middle income; Cote d'Ivoire: lower middle income; Benin: low income; Niger: low income; Cape Verde: lower middle (gave the least); Togo: low income.

91 IHR, above n 1, art 44.1(d).

92 Global Health Security Agenda, *About the GHSa* <<https://www.ghsagenda.org/about>>.

was created and adopted by WHO to monitor and evaluate the country's capacities under the IHR. The JEE specifically provides an evaluation framework for, among others, a states party's "legal framework to support and enable the implementation of all of their obligations and rights to comply with and implement the IHR (2005)".⁹³ The JEE target for legislation also evaluates whether state parties have "adequate funding for IHR implementation through national budget or other mechanisms."⁹⁴ For example, Zimbabwe's 2018 JEE report identifies the need for the country to conduct "a comprehensive assessment of legislation, regulations, administrative requirements, and other governmental instruments, to determine if they facilitate full implementation of the IHR (2005)".⁹⁵ Through the information provided by JEEs, states parties with certain experiences or regional similarities can collaborate with other countries in strengthening their national legal and regulatory framework for integrating the IHR.

4.2 WHO action

WHO also undertakes action that could constitute collaboration for the purposes of Article 44. As part of WHO's mainstreaming functions, and with a goal of honing best practices and collaborating towards the implementation of the IHR, WHO established the Strategic Partnership for International Health Regulations and Health Security (SPH), a hub that brings together states parties, partners and donors to share information.⁹⁶ As part of this program, WHO has created an online partner-matching system to "enable countries, partners and donors to efficiently and rapidly match needs and gaps with resources and priorities to effectively improve health security".⁹⁷ Donors or partners can determine which IHR area, region, and country they wish to support and, through the website, contact the WHO Country Office to engage in collaboration. Similarly, states parties in need of support can indicate the IHR areas in which they require support and, through the website, can contact donors who are interested in funding those areas.⁹⁸ Assuming it works, this system would allow

93 WHO, *JOINT EXTERNAL EVALUATION TOOL: INTERNATIONAL HEALTH REGULATIONS (2005)* (2016) 6.

94 Ibid.

95 Ibid, 7.

96 World Health Organization, *Strategic Partnership for International Health Regulations (2005) and Health Security (SPH) Strategic Partnership Networks* <<https://extranet.who.int/sph/networks>>.

97 World Health Organization, *Strategic Partnership for International Health Regulations (2005) and Health Security (SPH) Partner Matching* <<https://extranet.who.int/sph/partner-matching>>.

98 Ibid.

WHO to use its stewardship function to facilitate collaboration among states parties on different areas of IHR implementation.

WHO and its regional offices' response during the Zika epidemic in Latin America in 2016 provide further insight into how collaboration with states parties during a disease outbreak can occur, particularly through the flow of information and the provision of technical support. For example, WHO launched a global Strategic Response Framework and Joint Operations Plan, which focused on mobilizing and coordinating states to collaborate with countries in surveillance, response, and research on the Zika virus.⁹⁹ To ensure the sharing of information, WHO also established an online Emergency 4Ws Portal that recorded which states were doing "what, where, and when, at the global, regional, and national level".¹⁰⁰ The WHO online portal also compiled public information materials about the Zika virus and its potential complications, including videos, Q&A's, factsheets, infographics and timelines, which intended to provide health workers, researchers, policymakers, and the public with access to information about the disease.¹⁰¹

WHO also provided technical support during the Zika outbreak by publishing a weekly situation report to provide the latest epidemiological data to the public, as well as translations for 16 expert guidance documents on relevant topics ranging from psychosocial support for mothers, to surveillance guidance for entomologists. In addition, WHO developed Zika applications for smartphones to keep health workers and the public connected to the latest guidance and developments.¹⁰² Beyond WHO headquarters in Geneva, its regional office for the Americas – the Pan American Health Organization – was highly active in supporting states to bring the epidemic under control.

5 Conclusion

Consistent throughout all versions of the IHR is the recognition that infectious diseases require international cooperation to prevent their spread across borders. This imposes both individual duties on states parties and mutual and shared obligations within the international community. Article 44 is one tool

99 WORLD HEALTH ORGANIZATION, *ZIKA VIRUS OUTBREAK GLOBAL RESPONSE* (2016) 4 <<https://www.who.int/emergencies/zika-virus/response/en/>> [hereinafter *ZIKA OUTBREAK RESPONSE*].

100 *Ibid.*, 5.

101 *Ibid.*, 5.

102 *Ibid.*

found within the revised IHR that provides insight into how the world can engage in effective disease control for current and future outbreaks.

The legal interpretation of Article 44's obligations presented in this consensus statement was based on the ordinary meaning of the article's text within the context, in light of the object and purpose of the IHR, and supported by supplementary means. Most importantly, this analysis shows that there is a common and shared responsibility among states parties to make it possible for every country to achieve the minimum core public health capacities identified in the IHR. While Article 44 does not specify how countries must implement their individual obligations pursuant to this common and shared responsibility, the IHR legally requires countries to determine their level and type of collaboration in good faith considering the IHR's object and purpose, differing abilities among countries, and WHO's important role in this area.

This conclusion reveals gaps in the text of the IHR, particularly with regard to Article 44. Although there are clear obligations under Article 44, it is not possible to individually determine the exact level and type of collaboration required from each state party and WHO using the *Vienna Convention's* general and supplementary rules of interpretation. Given the importance of collaboration for achieving obligations required by the IHR, the inability to precisely interpret how Article 44 duties should be implemented by each country is problematic because it significantly raises the likelihood that states parties will not fulfill their legal obligations. This consensus, however, presents an opportunity for action. Article 44 should be further examined to either formally revise it or to negotiate a subsequent agreement regarding its interpretation – the latter of which could be implemented through a resolution of the World Health Assembly. Short of re-negotiation the IHR or adopting supplementary international instruments, WHO with partners, could offer detailed guidance on how states parties could fulfill their duties. It could similarly implement transparent monitoring and accountability mechanisms. The WHO's Joint External Evaluation (JEE) is a prime example of a measure implementing the IHR. It could consider other compliance enhancing incentives.

Additional research on different possible approaches for how countries can implement their individual obligations pursuant to Article 44's common and shared responsibility would be especially helpful, along with further analyses of how the IHR can be strengthened more broadly to ensure that its object and purpose can be more fully realized. In the meantime, we hope this consensus statement provides an authoritative legal interpretation of the IHR's Article 44 that countries can depend upon when implementing their existing collaboration obligations that should, in turn, enable enhanced global preparations for and responses to ongoing and future inevitable pandemics.

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